AGRICULTURAL EXTENSION SERVICE, UNIVERSITY OF MINNESOTA

4-H M-172

4-H HEALTH INFORMATION CARD

(Print clearly, fill out completely)

The information requested will be used to provide proper medical treatment to the member at a 4-H event in case the need arises.

Name _____ Age ____ Date of Birth _____ (County) _____ Sex ____
Last First Initial

In Case of Emergency Notify: Name _____ Phone ( ) Number _____
Area Code

Address _____
Street or Number City Zip

Relationship (Mark One) ☐ Parent, ☐ Guardian, ☐ Other _____

Alternate Contact in Emergency _____ Phone ( ) _____
Area Code

Family Physician or Clinic _____ Phone ( ) _____
Area Code

Address _____
Street or Number City Zip

Parent Authorization

The health history listed on the back is correct as far as I know, and the above named member has my permission to engage in all program activities at this event except as noted.

I understand that a registered nurse and/or health services will be available during the 4-H activity in which this member will participate and that adult supervision will be provided.

If a serious illness or injury develops, medical and/or hospital care will be given. Staff members for the activity are not responsible in case of accidental injury or illness.

I further understand that in case of medical emergency I will be notified. In the event I cannot be reached I hereby give my permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the child as named above.

Signature of Parent or Guardian _____

Date _____

HEALTH HISTORY

Member has or is subject to: (check if yes)

- ☐ Asthma
- ☐ Bronchitis
- ☐ Other (list) _____
- ☐ Convulsions
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Heart Trouble

Allergies or reactions to: (check those appropriate)

Drugs: ☐ Penicillin ☐ Aspirin ☐ Other (list) _____

☐ Tetanus antitoxin
☐ Tetanus toxoid
} Date of Last Tetanus shots _____

- ☐ Foods (what foods) _____
- ☐ Hay Fever
- ☐ Insect Bites or Stings
- ☐ Ivy, oak, and/or sumac poisoning

Member has difficulty with: (check if yes)

- ☐ Eyes, ears, nose, throat
- ☐ Lungs
- ☐ Other (list) _____
- ☐ Digestion
- ☐ Bed wetting
- ☐ Menstrual problems
- ☐ Sleep walking

Member has a condition now requiring medication? ☐ Yes ☐ No

If yes, please indicate condition _____

Is medication in possession of member? ☐ Yes ☐ No

Name of medication _____

List any specific Activities to be Restricted. _____

_____

When Water Sports are a part of the activity, my child may participate in:

Swimming ☐ Yes ☐ No Diving ☐ Yes ☐ No

Canoeing or Boating ☐ Yes ☐ No